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No. 08-869

IN THE
SUPREME COURT OF THE UNITED STATES

PHYLLIS J. WOGAN, INDIVIUALLY AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JAMES JOHN WOGAN

Petitioner,

v.

KENNETH C. KUNZE, M.D. AND HILTON HEAD GASTROENTEROLOGY, P.A.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SOUTH CAROLINA SUPREME COURT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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STATEMENT OF THE CASE

The Petitioner, Phyllis J. Wogan, individually and as Personal Representative of the Estate of James John Wogan, brought this action alleging only state law causes of action against the Respondents Kenneth C. Kunze, M.D. and his medical practice, Hilton Head Gastroenterology, P.A., in addition to other defendants.

The Petitioner's husband, James J. Wogan, was diagnosed in 1997 with rectal cancer. At that time, he began chemotherapy treatment with Gary Thomas, M.D., an oncologist. Mr. Wogan developed a severe case of diarrhea resulting in malnutrition and dehydration, for which he was referred to Dr. Kunze, a gastroenterologist. Dr. Kunze performed a colostomy in order to stop the diarrhea; however, the procedure did not remedy the problem. Dr. Kunze placed Mr. Wogan on the drug Sandostatin SC which was inserted subcutaneously three times a day and was not covered by Medicare.

After determining that the drug was effective at controlling the diarrhea, Dr. Kunze informed the Wogans that he would change the medication to Sandostatin LAR, a long acting form of the medication which could be administered monthly. The Petitioner alleges that the Sandostatin LAR is covered by Medicare although that factual question is disputed. She further alleges that Dr. Kunze originally indicated he would pre-order the Sandostatin LAR, administer it in his office, and submit the claim to Medicare.

According to the Petitioner, Dr. Kunze later refused to pre-order the Sandostatin LAR and administer it in his office because he did not believe that it was covered by Medicare unless the diarrhea was caused by the chemotherapy. The Petitioner consulted with Dr. Thomas to determine whether

he would prescribe and administer the medication, but he declined. Dr. Thomas was of the opinion that the diarrhea was not caused by the chemotherapy and would not be covered by Medicare. Dr. Kunze ultimately agreed to administer the Sandostatin LAR in his office, but he required the Wogans to purchase the monthly dose directly from the pharmacy.

The Wogans purchased the Sandostatin LAR at a cost of approximately $2,000 for three months. Neither Dr. Kunze or Dr. Thomas would assist the Wogans with filing a Medicare claim. Mr. Wogan subsequently died in October 2001.

The Petitioner filed this state court action alleging that Dr. Kunze and his practice were negligent in failing to file Medicare claims for the Sandostatin LAR. She also alleged that Dr. Kunze breached his contract with Medicare and that Wogan was a third-party beneficiary to that contract. Finally, she alleged claims for breach of fiduciary duty, a violation of the South Carolina Unfair Trade Practices Act (UTPA), and loss of consortium.

The trial court granted partial summary judgment to Dr. Kunze and his medical practice, finding that the Medicare Act did not provide for a private right of action. On appeal, the South Carolina Court of Appeals affirmed the lower court. *See, Wogan v. Kunze*, 366 S.C. 583, 623 S.E.2d 107 (Ct. App. 2005). The South Carolina Supreme Court granted certiorari. In her petition to that court, the Petitioner abandoned her breach of contract and UTPA claims.

The South Carolina Supreme Court affirmed the summary judgment as modified. The court concluded that "there are some circumstances in which a state law negligence claim may be maintained against a third party as a result of the denial of Medicare benefits." *Wogan v. Kunze*, 379 S.C. 581, 666 S.E.2d 901, 904 (2008). The court

explained that "whether a state common law action for negligence may be maintained depends ... on whether or not the plaintiff's claims are, at bottom, a claim seeking payment of reimbursement of sums which are alleged to be covered by Medicare, or whether the claims are wholly independent, but nonetheless stemming from the failure to provide some type of Medicare service." 666 S.E.2d at 905. The court affirmed the summary judgment for Respondents because "it is, at bottom, a claim for reimbursement of the $2000 per month which was expended on Sandostatin LAR prior to Mr. Wogan's death." *Id.* The court reached the same result with respect to the breach of fiduciary duty claim.

Importantly, the Petitioner did not raise any federal constitutional claims in seeking a writ of certiorari from the South Carolina Supreme Court. No constitutional claims are pled in the Petitioner's amended complaint. (App. 68-107). Further, the Petitioner did not raise any due process or equal protection claims or arguments to the South Carolina Supreme Court until after that court issued its decision. The due process and equal protections arguments were made for the first time in a petition for rehearing which was summarily denied.

REASONS FOR DENYING THE PETITION

I. Introduction

The Petitioner has abandoned her state law claims with the exception of her negligence and breach of fiduciary duty claims. She alleges that the Respondent Kenneth Kunze, M.D. breached both the standard of care for medical practitioners and a fiduciary duty in failing to submit Medicare claims for Sandostatin LAR totaling approximately $6,000.00. She insists incorrectly that Medicare regulations prohibited her husband from submitting his own claims to Medicare to recover the costs of the medication if indeed the medication were covered by Medicare, which is an issue of fact in dispute.

The Petitioner concludes that the South Carolina Supreme Court affirmed the dismissal of her state law claims on the basis of preemption. She has therefore presented three questions for consideration of this Court, none of which were presented to the lower courts.

II. South Carolina Supreme Court Did Not Expand the Scope of Medicare Act Preemption.

The Petitioner alleges that the South Carolina Supreme Court improperly expanded the scope of Medicare Act preemption. She insists that the South Carolina Supreme Court analyzed the case under the "jurisdictional provisions" of 42 U.S.C. § 405(h) rather than the "preemptive provisions" of that statute.

To fully understand the scope of the decision of the South Carolina Supreme Court, it is necessary to review the decision that was under review by that court. In the South Carolina Court of Appeals, that intermediate appellate court

examined through a detailed analysis whether there is an express or implied right of action under the Medicare Act, 42 U.S.C. § 1395. That court concluded that "there is no right of action, either express or implied, relating to the failure of a physician to file a claim under 42 U.S.C. § 1395w-4(g)(4)(A)." *Wogan v. Kunze*, 366 S.C. 583, 623 S.E.2d 107, 112 (Ct. App. 2005). That court indeed noted that the Petitioner "concedes there is no *express* provision in the Act allowing her to sue the physicians for failing to file a claim. The Act provides for penalties and sanctions, but no private action." 623 S.E.2d at 113. Ultimately, the South Carolina Court of Appeals observed that the Petitioner "is asserting an action for violation of the Medicare Act under the rubric of a state law claim" and ruled that the Petitioner could not base her state law claims on a failure to file a Medicare claim. 623 S.E.2d at 117. The court found that the state law claims "were an attempt to create a private cause of action where none exists." 623 S.E.2d at 122.

In reviewing the Court of Appeals' decision, the South Carolina Supreme Court recognized that "Wogan does not contest the fact that case law generally holds there is no private right or action under the Medicare Act." *Wogan v. Kunze*, 379 S.C. 581, 666 S.E.2d 901, 904, n.5 (2008). The court further agreed with the ultimate ruling of the South Carolina Court of Appeals but found that the holding was "overly broad." 666 S.E.2d at 904. The court recognized that "there are some circumstances in which a state law negligence claim may be maintained against a third party as a result of the denial of Medicare benefits." *Id.*

Importantly, the Petitioner does not dispute here that the Medicare Act did not create a private right of action. In the lower courts, she simply maintained that the breach of a duty under the Medicare Act should serve as the basis for a state law negligence action. The South Carolina Supreme Court agreed except in those cases where those claims are "at bottom a claim seeking reimbursement of sums which are

alleged to be covered by Medicare." *Wogan*, 666 S.E.2d at 905.

In drawing the distinction between what violations of the Medicare Act may be the subject of a state law tort claim under South Carolina law and which claims may not, the South Carolina Supreme Court cited to this Court's decision in *Heckler v. Ringer*, 466 U.S. 602 (1984). In that case, this Court explained that the petitioners' claims were "at bottom" claims seeking payment for their surgery. This Court held that claims that are "inextricably intertwined" with a claim for Medicare benefits may not be judicially pursued until all levels of administrative remedies are exhausted. 466 U.S. at 614. However, *Heckler* does not require exhaustion of administrative remedies for those claims that are not "inextricably intertwined" with but rather "wholly collateral" to the denial of benefits. 466 U.S. at 618. Thus, relying on *Heckler*, the South Carolina Supreme Court has applied that same distinction to South Carolina common law. If a state claim is "inextricably intertwined" with a claim for benefits and the remedy is the recovery of the Medicare benefits, then there is no state law right of recovery. The South Carolina Supreme Court found that the Petitioner's "claim is therefore 'inextricably intertwined' with the refusal to file a Medicare claim and is therefore not cognizable on state law negligence grounds." *Wogan*, 666 S.E.2d at 905.

The South Carolina Supreme Court's decision is not at odds with this Court's decision in *Heckler* nor any existing federal case law. The South Carolina Supreme Court's decision was not necessarily premised on federal preemption or even on the concept of exhaustion of administrative remedies. The decision, in effect, borrowed the rule from *Heckler* to limit the scope of the state common law. The court recognized that there may be negligence claims under South Carolina law that may be premised on the violation of the Medicare Act. The court in fact explained that a "[v]iolation of a Medicare statute could conceivably be used

to support a state negligence claim where the state law claim is not inextricably intertwined with a claim for Medicare reimbursement." *Wogan*, 666 S.E.2d at 905, n.6. However, if the negligence claim is a claim seeking the recovery of Medicare benefits, then such a claim was "not cognizable on state law negligence grounds." *Wogan*, 666 S.E.2d at 905.

Nonetheless, even if the decision of the South Carolina Supreme Court may be construed as relying strictly on federal preemption and mandatory exhaustion of administrative remedies, there is no error. Section 405(h) provides:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or government agency except as herein provided. No action against [the Secretary] shall be brought under section 1331 or 1346 or Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h). The first two sentences of § 405(h) require administrative exhaustion. Because the Petitioner's claim is premised on the reimbursement or payment of Medicare benefits as a remedy, all levels of administrative review must first be exhausted. That is particularly true given that the Petitioner's state law claims require a coverage determination, i.e., whether the Sandostatin LAR was even covered under Medicare.[1] Clearly, the Petitioner is

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[1] The Petitioner maintains that "there is no doubt" that the cost of the medication would have been covered by Medicare. That is incorrect. It is disputed in this case whether the Sandostatin LAR was even covered by Medicare. Dr. Gary Thomas testified that the Sandostatin LAR was not covered by Medicare because the diarrhea was not caused by the chemotherapy.

precluded from pursuing her state law claims when she has failed to initially exhaust her administrative remedies.

Moreover, the provisions of § 405(h) operate in tandem. The third sentence of § 405(h) provides that "§ 406(g), to the exclusion of 28 U.S.C. § 1331, is the sole avenue for judicial review for all 'claims arising under' the Medicare Act." *Heckler*, 466 U.S. at 615. Therefore, once administrative remedies are exhausted, a Medicare beneficiary may seek judicial review; yet, in accordance with 42 U.S.C. § 405(g), the review must be brought in a district court of the United States. *See, Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000) ("Section 405(h) purports to make exclusive the judicial review method set forth in § 405(g)"). Judicial review may not be sought by pursuing a state law tort claim in state court.

In sum, the South Carolina Supreme Court, as did the South Carolina Court of Appeals, did not necessarily decide this case on the basis of preemption or exclusive federal jurisdiction or even exhaustion of administrative remedies. Instead, the courts applied the principle that there is not an express or implied right of action under the Medicare Act for the failure of a physician to file a claim and concluded that no such private right of action exists under state common law as well. It is the prerogative of the South Carolina appellate courts to set the parameters of state common law, and this Court has no jurisdiction to review or reverse a state's determination of its common law.

Nonetheless, even if the decision of the South Carolina Supreme Court is read as applying federal preemption and mandatory exhaustion of administrative remedies under the Medicare Act, the court was correct in holding that a claim that seeks the recovery of Medicare benefits as a remedy and is "inextricably intertwined" with a claim for benefits may not be the subject of a state law tort claim or breach of fiduciary claim. There is no dispute that the Petitioner is

seeking in the present case the recovery of approximately $6,000 which was paid for three prescriptions of Sandostatin LAR. The state law claims are inextricably intertwined with a Medicare claim as evidenced by the fact that a determinative issue will be whether Medicare even covered the Sandostatin LAR. Consequently, the South Carolina Supreme Court ruled correctly that the Petitioner could not pursue the reimbursement or payment of Medicare benefits as damages by means of a state law claim.

III. Petitioner's Due Process and Equal Protection Arguments are Not Preserved and are Erroneously Premised on the Notion that a Medicare Beneficiary Cannot File His Own Claim.

The Petitioner has also raised due process and equal protection arguments in her petition. Those arguments were not raised at the trial level and, in fact, were raised for the first time only in a petition for rehearing to the South Carolina Supreme Court.

South Carolina appellate law clearly provides that a party may not raise an issue for the first time in a petition for rehearing. The South Carolina appellate courts routinely reject attempts to raise new issues or arguments in a petition for rehearing. For instance, in *Kennedy v. South Carolina Retirement System*, 349 S.C. 531, 564 S.E.2d 322 (2001), the South Carolina Supreme Court explained that "[t]he purpose of a petition for rehearing is not to present points which lawyers for the losing parties have overlooked or misapprehended, nor is it the purpose of the petition for rehearing to have the case tried in the appellate court a second time." 564 S.E.2d at 322. *See also, Kleckley v. Northwestern National Cas. Co.*, 338 S.C. 131, 526 S.E.2d 218 (2000) (issue raised for first time in petition for rehearing not preserved for review); *Liberty Loan Corp. of Darlington v. Mumford*, 283 S.C. 134, 322 S.E.2d 17 (Ct. App. 1984) (same).

Nonetheless, even if this Court were to consider these constitutional claims that were not timely raised below, the Petitioner's position is flawed. The Petitioner's argument is based on the erroneous position that a Medicare beneficiary is barred from filing his own Medicare claim for reimbursement of the costs of a covered medication. In making this argument, the Petitioner cites only to 42 C.F.R. § 414.707(b) which provides: "Effective with services furnished on or after February 1, 2001, payment for any drug covered under Part B of Medicare may be made on an assignment-related basis only." 42 C.F.R. § 414.707(b). This regulation controls only the basis for *calculating* the payment amount. It does not restrict, as the Petitioner suggests, who may seek Medicare reimbursement. It does not prohibit a Medicare beneficiary from filing his own claim for reimbursement. In fact, the Medicare Program Memorandum (App. 118) supports this very point. The Program Memorandum provides:

> Under § 114 of BIPA, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except the Medicare Part B deductible and coinsurance amounts.

(App. 118-119). The regulation clearly affects the calculation of the amount of the payment and does not restrict the person who may make a claim.

Medicare regulations establish the ability of a beneficiary to file his own claim. Specifically, 42 C.F.R. § 424.5(a)(5) sets forth who may make a claim for payment. It provides that "the provider, supplier, *or beneficiary*, as appropriate, must file a claim that includes or makes reference to a request for payment." 42 C.F.R. § 424.5(a)(5). (Emphasis added). As an additional example, 42 C.F.R. § 405.906 identifies the "parties

to the initial determination" as including "a beneficiary who filed a claim for payment under Medicare Part A or Part B ..." 42 C.F.R. § 405.906(a)(1).

Therefore, a Medicare beneficiary has the right to file his own claim for reimbursement under Part B. By filing his own claim, that beneficiary may then seek review of any adverse decision through the administrative process, and if not satisfied by the administrative process, he may then seek judicial review. As indicated, the judicial review is not sought, however, by pursuit of a state law negligence claim, but rather pursuant to the judicial review allowed under 42 U.S.C. § 405(g). In sum, a Medicare beneficiary is not deprived of his due process rights, and hence, there is no basis for the issuance of a writ of certiorari on that basis.

CONCLUSION

For the foregoing reasons, the Respondents submit that the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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